DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1008 (Rev. 08/05)

STATE OF WISCONSIN
HFS 107.31(2)(b), Wis. Admin. Code

WISCONSIN MEDICAID
NOTIFICATION OF MEDICAID HOSPICE BENEFIT ELECTION

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

This form is mandatory; use an exact copy of this form. Wisconsin Medicaid will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form.

Instructions: Type or print clearly. This form has two pages; always complete Section I and any other sections of the form that apply to the recipient. When complete, mail the form to the following address:

Wisconsin Medicaid
Recipient Services
PO Box 6678
Madison WI 53716-0678

SECTION I — COMPLETE FOR ALL HOSPICE RECIPIENTS

The recipient named on this form has elected to receive Medicaid hospice benefits. The recipient signed the Recipient Election of Medicaid Hospice Benefit form, HCF 1009, on the date indicated below and has been certified by a physician as having six (6) months or less life expectancy if the illness follows its usual course. The recipient's hospice has the Physician Certification/Recertification of Terminal Illness form, HCF 1011, on file.

Name — Recipient (First, middle initial, last)	Recipient's Medicaid Identification Number	Date Election Form Signed

Name — Hospice	Hospice's Medicaid Provider Number

Name — Attending Physician	Attending Physician's Medicaid Provider No.	Is the Attending Physician Employed by the Hospice?
		❑ Yes ❑ No

SECTION II — COMPLETE FOR RECIPIENTS RESIDING IN A NURSING HOME AT THE TIME OF HOSPICE ELECTION

The hospice and nursing home named below are in agreement that the hospice shall provide hospice services, while the nursing home shall provide room and board services as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95 percent of the nursing home's current skilled nursing facility (SNF) daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

Name — Nursing Home	Nursing Home's Medicaid Provider Number	Level of Care

Continued

SECTION III — COMPLETE FOR RECIPIENTS ENTERING A NURSING HOME AFTER HOSPICE ADMISSION

The hospice and nursing home named below are in agreement that the hospice shall provide hospice services, while the nursing home shall provide room and board services as defined under COBRA, P.L. 99-272. “Room and board” includes the performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the resident’s room, and supervision and assistance in the use of DME and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95 percent of the nursing home’s current SNF daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

Name — Nursing Home	Nursing Home’s Medicaid Provider Number	Date Admitted to Nursing Home

SECTION IV — COMPLETE FOR REVOCATION OF MEDICAID HOSPICE BENEFITS

The recipient named below has decided to discontinue the Medicaid hospice benefit on the date indicated.

Medicaid Identification Number — Recipient	Hospice’s Medicaid Provider Number	Date Recipient Signed Revocation Form
Name — Attending Physician	**Attending Physician’s Medicaid Provider No.**	**Is the Attending Physician Employed by the Hospice?**
		❑ Yes ❑ No

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